Chapter 4

Intervention Options for Societies, Communities, Families, and Individuals

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A traumatic stress perspective sheds a particular light on challenges facing the United Nations system—from poverty and exclusion in peacetime to displacement and deprivation in war or after disaster. It is an ever-evolving perspective or lens, and one that needs adjustment for cultural, gender, age, and other dynamic variables. It also needs adjustment according to the size of the targeted population, be it an entire nation or specific communities, families, or individuals. At its core is a concern for how human beings experience and respond to intolerable or traumatic stressors. From that core concern, a traumatic stress perspective then considers what might be desirable in terms of prevention, practice, and policy to alleviate suffering and improve quality of life. A broad menu of possible interventions is presented throughout this book, each of which must be understood in context and within a continually expanding knowledge base about the nature and consequences of traumatic stressors.

An inverted pyramid (see Chapter 11; De Jong 2002a) is used as an organizing and prioritizing concept throughout this book. Starting at the top and widest level, it targets progressively, and in descending order, ever-smaller groups of people (as shown in Figure 4.1). The target groups and levels of intervention are overlapping and interrelated. At the top of the pyramid are societal interventions designed for an entire population, such as international and national laws, public policy, and public institutions supporting human security, equality, dignity, and participation (Marsella,

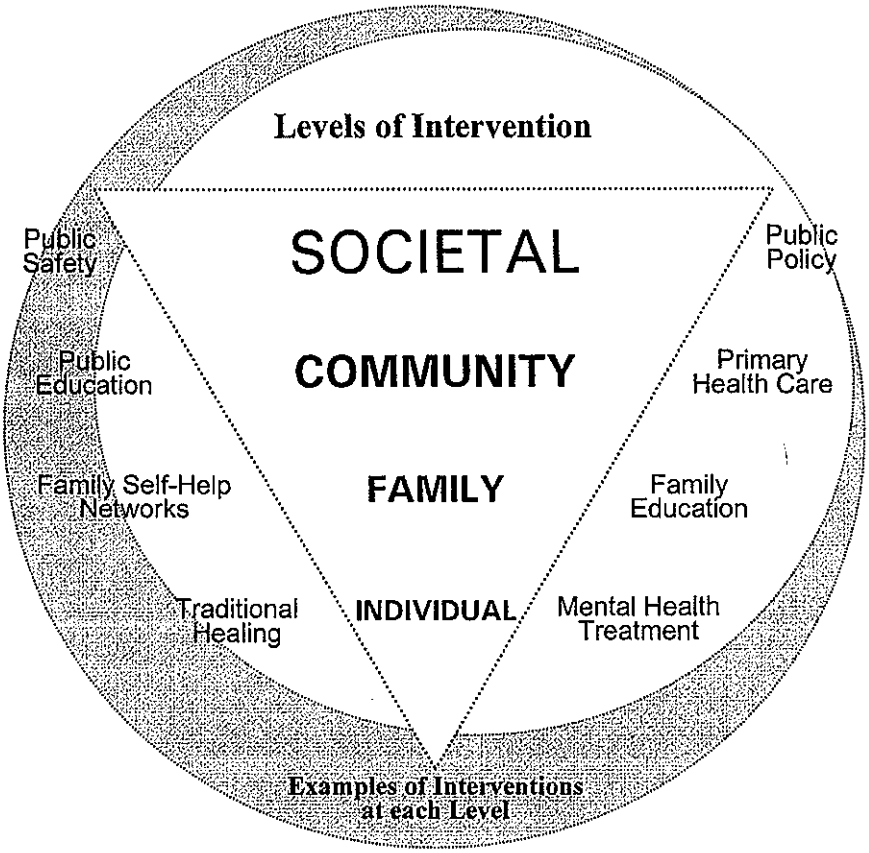

Figure 4.1. Model for Interventions in Social and Humanitarian Crises from a Traumatic Stress Perspective.

1998; De Jong, 2002b). At this broadest level, the aim is to remedy the violence that is inherent in the social structure (structural violence), violence that creates inequality, injustice, and exclusion, as well as interpersonal and collective traumatic stressors that interfere with a safe environment conducive to healthy adjustment. The next layer is community interventions, which include public education, support for community leaders, preservation of social infrastructure, local empowerment, and training and education of local health workers. The next layer from the top is family interventions that focus on the individual within the context of family and clan, as well as on strategies to promote the well-being of the family as a

unit. The bottom layer of the pyramid concerns interventions primarily designed for the individual with psychological symptoms or psychiatric disorders. These include individualized treatments and services provided by practitioners of traditional methods of healing as well as Western-oriented psychosocial interventions and psychiatric medication. Because the last are the most expensive and labor-intensive approaches and require the most highly-trained staff, they are reserved for the small minority of individuals who have not benefited sufficiently from the larger-scale interventions at higher levels of the pyramid.

There is considerable variation worldwide between high- and low-income countries, and among ethnic, religious, and cultural groups, in ways of coping with intolerable or traumatic stressors, as can be seen by the range of examples given throughout the book. Differences exist among nations and cultures in the kinds of help that are available and perceived as appropriate to prevent and cope with traumatic stressors (Patel, 2000). In many low-income countries, traditional healers provide interventions that are related to the cultural beliefs of communities, families, and individuals, and they far outnumber professional mental health workers trained in Western-oriented systems of care (Asuni, 1979). In these countries, services provided by traditional healers are more accessible and more widely used than professional health services (Leff, 2001). Although there are fewer traditional healers in many high-income countries, there is a growing interest in many of the methods of traditional medicine (Hopa, Simbayi, & Du Toit, 1998).

High-income countries customarily address traumatic stress responses through psychosocial and/or mental health interventions. Psychosocial interventions address social problems (such as homelessness, alcoholism, discrimination, or violence in the family) that affect emotional or psychological well-being, and psychological problems (such as despair or fear) that undermine social functioning, including a capacity for intimacy, work, and participation in family and communal life. Psychosocial interventions include public health announcements, self-help and community groups, and school debates (on violence, for example), as well as counseling services, emotional support, and problem-solving for various population groups. Programs such as disaster preparedness education, skills training, school-based violence prevention programs, and long-term follow-up may be important steps in effectively treating trauma survivors.

Mental health interventions most often target psychiatric disorders, such as posttraumatic stress disorder (PTSD), diagnosed according to official criteria of the World Health Organization (WHO, 1992) or the American Psychiatric Association (1994) (see Chapter 2). Mental health interventions

often include psychotherapy and/or medication for the patient as well as education and/or counseling to the patient and his or her family. The majority of mental health professionals in high- and low-income countries have been trained in disease-oriented models of mental health and are frequently most comfortable with this approach. However, people with psychiatric disorders are also vulnerable to psychosocial problems, thereby creating the need to provide psychosocial services to the individual or his or her family or community.

There is a wide disparity across nations in the amount of public and private resources available for psychosocial and mental health interventions, and in the extent to which trauma services are integrated into community health or mental health systems. In the few countries in which trauma prevention and treatment systems are in place, they are often poorly integrated with other health care. Fragmented and ineffective care is often the end result. The United States, for example, is one of the countries that fail to integrate mental health services fully within its public health response to emergency events.

This book—while emphasizing current best practices—also attempts to contribute to an emerging debate on the prevention and remedy of intolerable or traumatic stress. Such stress is being experienced by entire societies worldwide, and within communities, families, and individuals. Our goal is to generate questions, elicit and collect diverse and innovative responses, support communal healing, and cultivate exchange among traditional, psychosocial, and mental health-oriented approaches to the prevention of traumatic stressors and treatment of their consequences. It hopes to support exchanges and collaboration among systems of treating traumatic stress worldwide as well as between mental health and political, economic, and social systems.

LEVELS AND TYPES OF INTERVENTION

Level 1: Societal Interventions

Policy/Public Safety. International and national laws, public policy, and public institutions can all influence the prevalence and impact of exposure to traumatic circumstances. A first line of prevention is the provision for the basic human needs of water, food, safety, shelter, education, and employment; these self-evidently reduce environmental stressors and empower populations to manage their affairs. Thus, national development plans and, relatedly, national health care, employment, welfare, and other systems are all critical to the prevention and treatment of adverse

consequences in the wake of large-scale traumatic stressors. Governments play a key role in establishing public safety through the development of policies and systems that prevent or ameliorate the stresses of wars, disasters, and the abuse of women, children, the elderly, and persons with disabilities. Establishing public safety in the aftermath of civil strife and violence, political instability, and natural disasters is an essential element for building an environment conducive to reducing the impact of traumatic stress. Unfortunately, few national systems are adequately prepared for large-scale social or humanitarian crises. The World Health Organization emphasizes the role of disaster preparedness and response through training, assessment of health situations and needs, and coordination among agencies involved in trauma prevention and response operations (De Girolamo, 1993). For example, nations prone to earthquakes may prevent or diminish the traumatic consequences of these natural disasters by developing, implementing, and enforcing building safety codes and standards, and by establishing plans for emergency preparedness and public safety (Abdo, Al-Dorzi, Itani, Jabr, & Zaghloul, 1997).

Official recognition and acknowledgment of the presence of traumatic stressors by the United Nations, national governments, and NGOs is a viable form of societal intervention. Using an interpersonal-level traumatic event as an example, the United Nations' definition of torture has brought considerable recognition to that form of traumatic stressor. The World Health Organization's definition similarly highlighted the problem of torture and gave it greater visibility internationally and, in particular, among health care providers. Coupled with the efforts of Amnesty International, which investigates and estimates the prevalence of torture across all nations, these international efforts have shed valuable light on a common traumatic event plaguing contemporary society.

Efforts to define and measure the many forms of intolerable stress in populations can lead to an assessment of their prevalence, a process that itself raises public awareness, which in turn may reduce the frequency of these events and lead to the development of intervention strategies. In this respect, the ongoing refinement of indicators throughout the UN system—regarding hunger, homelessness, unemployment, lack of schooling, the flow of migrants and refugees, and the status of women, disabled persons, older persons, and youth, among others—begins the process of prevention of traumatic stress exposure.

Ensuring social justice by addressing basic human rights, discrimination, exclusion, and powerlessness can remove enormous individual, familial, and communal stressors. Laws and the use of the criminal justice system can be both preventative and curative. The manner in which

a country's criminal justice system interacts with victims of crime can influence psychological outcomes for an individual. Systems that place exclusive emphasis on the perpetrator and his/her punishment may ignore those whose lives have been adversely affected by the victimization. Placing the victim at the center of the legal system, and focusing conjointly upon justice, punishment, reparation, and rehabilitation, may achieve a greater sense of social justice for all those affected by crime. The United Nations' *Declaration of Basic Principles of Justice for Victims of Crime* and the establishment of an International Criminal Court are important international efforts to delineate for countries those policies that, if implemented, would enhance the mental health of victims within countries.

Level 2: Community Interventions

In many communities worldwide, concerns about the social and psychological effects of traumatic exposure, and the treatment and care of those so exposed, are a lower priority than compelling physical health needs (Leff, 2001). However, the two aspects are interrelated (see Chapter 2), and attention to one will positively affect the other. Furthermore, programs to treat the consequences of exposure to traumatic stressors that are based upon local systems, values, and priorities are more likely to be successful than programs that neglect such realities in communities (Jacob, 2001). Community ownership of interventions is critical, and may be achieved by involving all population segments—women as well as men, elders as well as youth, local professional and health workers, and community leaders—in the development and implementation of interventions (Siriam, 1990).

Public Education. Public education through poster and leaflet campaigns, radio and Internet announcements, and workshops and discussion groups facilitates wide and rapid distribution of important information about, for example, safety, aid and resources, self-help, and legal rights in the aftermath of a traumatic stressor. It can inform people in communities affected by stressful events about the scope of those events and the range of normal or common reactions, as well as those that are more unusual or severe that might require extra attention. In humanitarian crises, when normal modes of communication with the outside are damaged, public education can be used to quell rumors and help the community to have a more realistic view of the situation. It can also assist communities in addressing alcohol or drug abuse in the aftermath of traumatic stressors. In individual or interpersonal level trauma, public education

can heighten public awareness about types of behavior that are not well known or understood, such as abuse of the elderly, or abuse of physically or mentally disabled individuals. With regard to preventing violence of all types—toward children, spouses, the elderly, persons with HIV/AIDS, and the disabled—public education can train key individuals or entire communities in peaceful methods of conflict resolution as a way of settling disagreements. Educational material that promotes positive local values, morals, and self-help can be presented in novel ways, such as drama and storytelling, that have the capacity to engage a larger or specialized audience.

Maintaining Local Structures. Activities such as meetings, rallies, or religious ceremonies that are conceptualized and implemented by leaders and individuals in the affected communities can generate a sense of healing and recovery. Some communities have structures for doing this. The Shraddhanjali mass grieving ceremony in Sri Lanka, for example, promotes unity and collective action within grief-stricken communities. In response to crises, such activities can be organized to occur more often initially, perhaps weekly, and then gradually decrease in frequency. Group meetings allow the community to participate as a unit. This kind of collective participation can stimulate brainstorming about methods for rebuilding the community as well as collective action in doing so. Folk and devotional songs about a tragedy can help the mourning process, and help to gather people in a common place to share their grief. Organizing a rally may help to sensitize officials regarding delays in the implementation of restoration, rebuilding, and relocation after a humanitarian crisis, or may heighten their awareness of ongoing community problems which have gone unacknowledged or unaddressed, such as the abuse or exploitation of children. Similarly, national advocacy groups can provide a focal point for education, public awareness, and service development.

Oftentimes, community cohesion can be sparked by simply encouraging adults and children to get back to their normal routines, or by making experiences possible that are likely to promote self-esteem, such as income-generating activities, training opportunities, or sports. Sports, for example, can encourage the constructive use of free time, which is particularly useful for dislocated communities such as those in temporary shelters or in refugee camps. They also provide a venue for children to talk about their experiences with others, a component vital for healing in many cultures. Youth workers or volunteers who facilitate such activities can be taught relevant listening skills, since children may choose to talk to youth workers rather than to teachers or parents (see Chapters 10 and 11).

Prevention and treatment may target the community as a whole, or may focus on vulnerable subgroups such as single and teenaged parents, low socioeconomic or isolated families, the elderly or disabled, or children—as well as vulnerable housing units, neighborhoods, or entire villages. Representatives of the target group must be involved in decision-making that affects them. Volunteers can be recruited and trained to visit with isolated elders or those with disabilities. Community "gatekeepers" who are advocates for the elderly or disabled can be trained to identify abuse and to reach out to isolated elders on the one hand, and community religious, business, and other leaders on the other. A proactive coordinated community approach to investigating cases of abuse also helps prevent abuse and facilitates early detection, when intervention may be more effective.

Enhancing Primary Health Care and Traditional Healing Systems. In many developing countries and rural regions of the world, primary health care workers provide most mental health services to trauma survivors, and traditional healers and religious leaders provide most psychosocial services to survivors. This can easily be seen as a necessity due to lack of trained professionals and resources to provide specialty services (Leff, 2001). However, "train-the-trainer" models provide a useful method for expanding outreach and for integrating and sustaining elements of the traumatic stress perspective into indigenous healing and primary health systems of care, a model that is re-emerging in the West. It also helps to embed knowledge within communities for the long-term, promoting community resilience. Up to five or more years may be required for train-the-trainer systems to take root, with local trainers in a position to continue interventions with minimal assistance from the original trainers. Monitoring and evaluation should be built into the system from the start, facilitating periodic adjustments at the end of a program cycle for each level and stage of intervention (De Jong, 2002b).

Schools. As respected members of the community, local teachers frequently play a critical role in assisting traumatized children, as demonstrated, for example, in the former Yugoslavia, Sri Lanka, and Mozambique. To be effective in complex human emergencies, teachers need training both in the curriculum and in classroom management in order to address the changed behavior of traumatized pupils. They also need to be trained to recognize the behavioral and emotional needs of the children. This training might include skills in talking with children about emotionally difficult matters in a way that helps them cope with their stress reactions, as well as training in how (and to whom) to refer the selected children for further

help. Teachers have a pivotal role when most of the affected children are in school. However, community nurses and physicians also have vital roles to play both in helping identify children in need and in organizing services to meet those needs, especially in more chaotic situations.

Level 3: Family Interventions

Interventions at the level of the family make use of informal support systems of family, friends, neighbors, peers, and local community organizations. Relying on natural helping networks, these interventions promote the capacity of family and/or a network of supporters to help family members cope with and recover from traumatic experiences. Interventions at the family level may include organizing "self-help" groups of families who share similar experiences, such as having a family member disappear, be murdered, or be abducted. Self-help groups are also helpful for families who are caring for members with disabilities. Interventions at this level may also assist families in generating income and obtaining other resources necessary for caring for a member who has survived a devastating traumatic experience. It is generally presumed useful to provide family members with accurate information about the nature and consequences of traumatic stress, and how they can best help survivors.

Where there is little social service infrastructure, reliance on social networks may be the most viable option. In some developed countries, interventions for child abuse and neglect emphasize family education and guidance, in a format that is flexible and responsive to the needs of children and families. For example, treatment of physical abuse may help parents and children to understand and re-focus anger, to develop communication and collaboration skills, and to examine distorted beliefs, such as low self-esteem, which often underlie family violence. Similarly, treatment for child neglect focuses on parenting skills and expectations, coupled with training in social competencies that may include home safety, family hygiene, finances, medical needs, drug and alcohol counseling, marital counseling, and other skills needed to manage family resources and to attend to children's needs.

Although family level interventions frequently focus on the needs of the individual within the context of the family, these interventions may also promote the psychosocial well-being of the family itself. Numerous studies indicate that traumatic experiences have effects on family members as well as on survivors and victims. For example, studies of the families of Holocaust survivors, survivors of the atomic bombing of Japan during World War II, refugees and internally displaced persons, and veterans of armed conflicts point to the transgenerational effects of traumatic stressors

on their children (Danieli, 1998). Family level interventions may therefore take into account the needs of not only the survivor, but also his or her family members. For example, one approach to the treatment of families of trauma survivors emphasizes the development of a shared understanding of the problem and the joint development and acceptance by the family of a "healing theory." However, when family members themselves are the perpetrators of trauma, as is often the case in abuse of children, the elderly, and the disabled, additional sets of complexities are introduced that are examined in specific chapters of this volume.

Level 4: Individual Psychosocial and Mental Health Interventions

People have coped with traumatic stress in ways unique to individual and culture-specific resources. For much of history, coping has been intuitive. That is, neither the individuals themselves nor the healing professions consciously analyzed the innate or inherited methods employed to see what worked and why (or didn't work and why not). Throughout centuries, traditional health-care systems, such as those of China and India, have developed approaches to treating the problems of survivors of traumatic experiences that include herbal remedies, meditation, exercise, and massage.

Western medicine has adopted a scientific approach—that is, a detached observation of cause and effect, together with testing, measuring, comparing, replication, and peer review—and this has also shaped its approaches to mental health. Today, Western analytic approaches to treating traumatic stress responses have largely examined three areas: cognitive behavioral therapy (CBT), psychodynamic and interpersonal therapies, and pharmacotherapy. These are typically provided by individuals with formal professional training and are usually indicated only under certain circumstances, such as the existence of a ICD-10 (World Health Organization [WHO], 1992) or DSM-IV (American Psychological Association [APA], 1994) diagnosis such as PTSD or major depression. These approaches are likely to have differing degrees of applicability across and within countries, both for cultural reasons and because resource constraints may render them inaccessible.

Additional approaches used internationally—for prevention and treatment—include various forms of meditation, deep muscle relaxation, acupuncture, and exercise adopted from traditional medicine, as well as psychological debriefing and supportive forms of psychotherapy, such as crisis counseling. Decisions to use individual psychosocial and mental

health interventions should consider the empirical evidence for a treatment's efficacy as well as the capacity of the intervention to accommodate the relevant cultural premises of communities and individuals (see Chapter 13; Tanaka-Matsumi & Higgenbotham, 1996).

PTSD is not the only formal psychiatric diagnosis associated with exposure to traumatic events (see Chapter 2). Major depression is an especially common outcome, and one that often co-occurs with PTSD. Anxiety disorders other than PTSD are also relatively common following trauma. Since PTSD is often the most common outcome, however, and since it is specifically linked with traumatic exposure, it will be the focus for the rest of this chapter. More detailed information can be found elsewhere (Foa, Keane, & Friedman, 2000).

Cognitive-Behavioral Therapy (CBT). CBT techniques for treating psychological distress in survivors of traumatic experiences include exposure therapy, cognitive therapy, cognitive processing therapy, stress inoculation training, systematic desensitization, assertiveness training, biofeedback, and relaxation training (Foa et al., 1999). Some of these are administered in a group format. To date, exposure therapy is the most rigorously evaluated individual intervention. Exposure treatment methods involve confronting fearful memories within the context of a safe therapeutic relationship. The process involves intentionally experiencing and maintaining the distress associated with the traumatic event until the distress diminishes.

Exposure therapy has been found to be effective in treating the symptoms of PTSD in war veterans and female sexual assault survivors (e.g., Rothbaum, Meadows, Resick, & Foy, 2000). It has also achieved widespread use in the treatment of child and adult victims of crime, child abuse, disasters, torture, and motor vehicle accidents. One form of CBT—cognitive processing therapy—alleviates the symptoms of depression and PTSD among rape survivors (Resick, Nishith, Weaver, Astin, & Feuer, 2002). Another useful CBT approach is stress inoculation training, which involves teaching individuals specific coping skills for reducing or managing symptoms and/or alternative responses to fear and anxiety. Skills include relaxation training, anger management training, thought stopping, assertiveness training, self-dialogue, problem-solving skills training, and relapse prevention (Meichenbaum, 1974). Relaxation techniques and self-dialogue through the repetition of a meaningful word, phrase, or verse to oneself is practiced in cultural and religious systems worldwide. Although CBT has extended the range of effective mental health treatments for PTSD in some developed nations, the generality of treatment efficacy to persons

with PTSD in other cultures is just beginning to be evaluated (Paunovic & Ost, 2001).

Psychodynamic Therapy. The psychodynamic formulation views traumatic stress as characterized by two alternating psychological states: one typified by intrusive thoughts, and the other by denial and numbing (avoidance). Psychodynamic interventions tailor treatment to the symptoms associated with the patient's current psychological state. Once intrusive and avoidance symptoms are within manageable limits, the full meaning of the event can be explored. From a psychodynamic perspective, posttraumatic symptoms represent an adaptive attempt to manage the trauma. If the meanings of these symptoms, as well as the meaning of the event, are understood and worked through, the patient will be able to cope more effectively. Psychodynamic treatment of PTSD is primarily an expressive therapy that seeks to increase the patient's understanding of material outside his or her awareness and to improve coping in the context of a strong therapeutic alliance. In comparison with CBT, psychodynamic therapy for traumatic stress has been subjected to much less empirical validation, although initial studies have demonstrated benefits, especially in the long-term (Brom, Kleber, & Defares, 1989). In recent years, psychodynamic techniques have begun to be adapted for use with patients from different cultures (e.g., Nathan, 1989). Interpersonal approaches that are similar conceptually and theoretically, but that focus more on the impact of trauma on current relationships, are also being developed (e.g., Krupnick, 2002).

Pharmacologic Approaches. A substantial body of research has demonstrated abnormalities in the psychobiological systems of persons with PTSD. Many medications have been used to treat specific PTSD symptoms, separately or in combination with psychotherapy. Pharmacologic treatments for PTSD include antidepressants, inhibitors of adrenergic activity, and mood stabilizers (Friedman, 2000). Among these drugs, the most carefully studied and most widely prescribed are the antidepressants. Of the antidepressants, the selective serotonin reuptake inhibitors (SSRIs) are currently regarded as the most efficacious drug treatment for PTSD. The US Food and Drug Administration has recently approved two SSRIs (sertraline and paroxetine) for use in PTSD (Friedman, Davidson, Mellman, & Southwick, 2000), the first medications so designated. Most developing countries have access to tricyclic antidepressants, but not SSRIs, through the *WHO List of Essential Medicines* (World Health Organization, 2001).

Crisis Counseling. Crisis counseling is a supportive intervention that provides traumatized individuals with an opportunity to express feelings

about the event within a nonjudgmental context. Crisis counseling is frequently provided to victims of violent crimes, such as rape or sexual assault, as well as to survivors of natural and manmade disasters. General characteristics of crisis counseling are: (a) it is time-limited and issues-oriented; (b) the counselor responds to the crisis requests of the victim; (c) the counselor responds to crisis-related problems and not to other problems; and (d) the counselor takes an active role in initiating follow-up contacts. This approach is often carried out by peer counselors who offer support, information, and empathy to the victim, as well as by trained mental health professionals through such programs as the Disaster Response Network (DRN) established by the American Psychological Association in collaboration with the American Red Cross. Over 1,500 DNR volunteers provide free on-site mental health services to disaster survivors and relief workers (APA, 2002).

Because provision of crisis counseling and psychotherapy to trauma survivors can be stressful for providers, training programs need to incorporate information about secondary traumatic stress (e.g., Pearlman & Saakvitne, 1995) and self-care for trauma professionals (see Chapter 15).

SUMMARY GUIDELINES

The following distillations will help to guide the selection of interventions for the prevention or remedy of traumatic stress in societies, communities, families, and individuals.

- In the aftermath of traumatic collective and individual-level social stressors, self-healing and self-correction occur at all levels. Yet downward spirals can also occur, making careful and timely intervention important. Timely intervention has the capacity to break cycles of distress and deprivation that may be "contagious," spreading outward to family and community or inward from the broader society to individuals and families, and frequently also to the next generation.
- The problems of those exposed to traumatic stressors show some universal characteristics across cultures, perhaps owing to the biological and cognitive dimensions of the nature of the threat, and to responses to traumatic events.
- Those experiencing traumatic stress, and those developing interventions for its prevention or remedy, are all conditioned to varying degrees by innate, experiential, and cultural differences, including gender, age, and other factors. In other words, not everyone experiences or sees traumatic stressors in the same way, making dialogue and openness essential for its

prevention and treatment. It is particularly crucial for interventions to be culturally and developmentally appropriate, as well as gender-appropriate.

- Interventions based on education and training are nearly universally accepted as appropriate—even as these interventions evolve through assessment and feedback from clients and practitioners working in new situations.
- Indigenous and traditional healing systems are the most widely used and accessible worldwide—applied variously by local traditional healers, primary health care workers, wise men and women, and community or religious leaders. There is a need to find creative methods to bridge the gap between traditional, national, and private health systems to better manage the care of survivors of traumatic stressors.
- As illustrated throughout this volume, a variety of psychosocial and mental health interventions exist. They may be neutral, beneficial, or even harmful. Timely, sensitive, and culturally-appropriate interventions can reduce the severity of reactions to traumatic stressors, lend hope for recovery, and prevent a deterioration of psychological status. Inappropriate interventions, however, can exacerbate traumatic conditions. Some may have no effect, however costly they may have been to implement. In short, the interrelationship of condition, intervention, and outcome is complex and needs continued study. Only thus can we help decision-makers devise suitable policies for prevention and treatment of traumatic stress, in war or peacetime situations, and at the levels of societies, communities, families, and individuals.

REFERENCES

Abdo, T., Al-Dorzi, H., Itani, A., Jabr, F., & Zaghloul, N. (1997). Earthquakes: Health outcomes and implications in Lebanon. *Le Journal Medical Libanais, 45*, 197–200.

American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

American Psychological Association (2002). Disaster Response Network: A pro-bono service of the American Psychological Association and its members. American Psychological Association Web site: http://www.apa.org/practice/drn.html.

Asuni, T. (1979). The dilemma of traditional healing with special reference to Nigeria. *Social Science and Medicine*, 13B, 33–39.

Brom, D., Kleber, R.J., & Defares, P.B. (1989). Brief psychotherapy for post-traumatic stress disorders. *Journal of Consulting and Clinical Psychology, 57*, 607–612.

Danieli, Y. (Ed.) (1998). *International handbook of multigenerational legacies of trauma*. New York: Plenum.

De Girolamo, G. (1993). International perspectives on the treatment and prevention of post-traumatic stress disorder. In J. Wilson & B. Raphael (Eds.), *International handbook of traumatic stress syndromes* (pp. 935–946). New York: Plenum.

De Jong, J.T.V.M. (Ed.) (2002a). *Trauma, war and violence: Public mental health in socio-cultural context*. New York: Kluwer/Plenum.

De Jong, J.T.V.M. (2002b) Public mental health, traumatic stress and human rights violations in low-income countries: A culturally appropriate model in times of conflict, disaster and peace. In J.T.V.M., De Jong (Ed.) (2002), *Trauma, war and violence: Public mental health in sociocultural context*. New York: Kluwer/Plenum.

Foa, E.B., Dancu, C.V., Hembree, E.A., Jaycox, L.H., Meadows, E.A., & Street, G.P. (1999). A comparison of exposure therapy, stress innoculation training, and their combination for reducing posttraumatic stress disorder in female assault victims. *Journal of Consulting and Clinical Psychology, 67*, 194–200.

Foa, E.B., Keane, T.M., Friedman, M.J. (Eds.) (2000). *Effective treatments for PTSD: Practice guidelines from the International Society for Traumatic Stress Studies*. New York: Guilford Press.

Friedman, M.J. (2000). A guide to the literature on pharmacotherapy for PTSD. *PTSD Research Quarterly, 11*, 1–7.

Friedman, M.J., Davidson, J.R.T., Mellman, T.A., & Southwick, S. (2000). Pharmacotherapy. In E.B. Foa, T.M. Keane, & M.J. Friedman (Eds.), *Effective treatments for PTSD: Practice guidelines from the International Society for Traumatic Stress Studies* (pp. 84–105). New York: Guilford Press.

Hopa, M., Simbayi, L.C., & Du Toit, C.D. (1998). Perceptions on integration of traditional and Western healing in the new South Africa. *South African Journal of Psychology, 28*, 8–14.

Jacob, K.S. (2001). Community care for people with mental disorders in developing countries: Problems and possible solutions. *British Journal of Psychiatry, 178*, 296–298.

Krupnick, J. (2002, May). Group IPT for PTSD after interpersonal trauma in low-income women. In *New applications of IPT* (Panel conducted at the meeting of the American Psychiatric Association, Philadelphia, PA).

Leff, J. (2001). Mental health services and barriers to implementation: Background information document. In *World Health Organization Ministerial round tables 2001: Mental health*. London: Institute of Psychiatry.

Marsella, A.J. (1998). Toward a "Global-Community Psychology": Meeting the needs of a changing world. *American Psychologist, 53*, 1282–1291.

Meichenbaum, D. (1974). Self-instructional methods. In F.H. Kanfer & A.P. Goldstein (Eds.), *Helping people change* (pp. 357–391). New York : Pergamon Press.

Nathan, T. (1987). Amenagement de la technique psychoanalytique dans les situations interculturelles. *Information Psychiatrique, 63*, 781–785.

Patel, V. (2000). The need for treatment evidence for common mental disorders in developing countries. *Psychological Medicine, 30*, 743–746.

Pearlman, L.A., & Saakvitne, K.W. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors*. New York: W.W. Norton.

Paunovic, N., & Ost, L-G. (2001). Cognitive behavior therapy vs. exposure therapy in the treatment of PTSD in refugees. *Behaviour Research and Therapy, 39*, 1183–1197.

Resick, P.A., Nishith, P., Weaver, T.L., Astin, M.C., & Feuer, C.A. (2002). A comparison of cognitive-processing therapy with prolonged exposure and a waiting condition for the treatment of chronic posttraumatic stress disorder in female rape victims. *Journal of Consulting and Clinical Psychology, 70*, 867–879.

Rothbaum, B.O., Meadows, E.A., Resick, P., & Foy, D. (2000). Cognitive-behavioral therapy. In E.B. Foa, T.M. Keane, & M.J. Friedman (Eds.), *Effective treatments for PTSD: Practice guidelines from the International Society for Traumatic Stress Studies* (pp. 60–83). New York: Guilford Press.

Siriam, T.G. (1990). Psychotherapy in developing countries: A public health perspective. *Indian Journal of Psychotherapy, 32*, 138–144.

Tanaka-Matsumi, J., & Higginbotham, H.N. (1996). Behavioral approaches to counseling across cultures. In P.B. Pedersen, J.G. Draguns, W.J. Lonner, & J.E. Trimble (Eds.), *Counseling across cultures* (4th ed.) (pp. 266–292). Thousand Oaks, CA: Sage.

World Health Organization (1992). *The ICD-10 classification of mental and behavioral disorders: Clinical descriptions and guidelines.* Geneva: Author.

World Health Organization (2001). *WHO Model List of Essential Drugs (EDL)* 11th Edition (Nov, 1999), World Health Organization Web site: http://www.who.int/medicines/organization/par/edl/infed11group.html